MEDICARE AND PRIVATE HEALTH INSURANCE

A Training Text

PUBS
RA
412
.3
M4216
1980

The HEALTH CARE FINANCING ADMINISTRATION (HCFA) was established to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review Program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

HCFA

Health Care Financing Administration

RA
412.3
.M4216
1980

MEDICARE AND PRIVATE HEALTH INSURANCE

A Training Text

Table of Contents

Introduction	5
What Medicare Covers	6
What Medicare Does Not Cover	30
Do You Need Private Health Insurance?	34
What Kinds of Private Health Insurance Can You Buy?	36
12 Shopping Hints for Buying Private Health Insurance	52
For Further Information	63
Using The Medicare/Private Health Insurance Checklist	64

Introduction

Medicare covers many of the health care expenses most elderly Americans face, particularly for hospital care and doctors' services. These costs are so high that lack of insurance protection could lead to serious financial problems when these services are needed. But Medicare does not cover these services in full and there a number of less expensive, but often necessary, health care services which Medicare only partly covers or does not cover at all.

For this reason, many private insurance companies offer health insurance to supplement Medicare. This insurance provides coverage to fill *some* of the gaps in Medicare. Deciding whether to buy private health insurance and choosing what kind is best suited to your individual situation are important, and not always easy, judgments to make.

This training text has been prepared by the Health Care Financing Administration, the Federal agency that administers the Medicare program, to give you information that will help you make the decision as to whether you need additional health insurance, what kind of health insurance might be best for you and what kinds of misleading sales practices you should be alert to.

Although we believe that study of this booklet will help you to be a better informed and a more careful purchaser, we recommend that you seek the advice of others before you buy. It is an important decision and getting a second opinion may be very helpful to you. If you have a knowledgeable friend or relative, or are a member of a senior citizens' organization, or there is a Senior Citizen Center, or Consumer Protection Agency or Legal Services for the Elderly organization in your areas, these are resources you may wish to use. In addition, the State Insurance Department of your State Government is a resource you can always draw on and many of them have prepared informational material on private health insurance that they will be glad to send you.

What Medicare Covers

BASIC PROVISIONS

Medicare is *two* separate programs — *Hospital Insurance* (sometimes called Part A) and *Medical Insurance* (sometimes called Part B).

Hospital insurance covers inpatient care in a hospital, inpatient care in a skilled nursing facility *after* a hospital stay and home health care services in your home *after* a hospital stay.

Medical insurance covers doctor's services, outpatient hospital services, home health services (without the need for a prior hospital stay), and a number of health care services, such as X-ray and laboratory services, ambulance services, physical therapy, and rental or purchase of durable medical equipment.

You can tell what Medicare coverage you have and when it began by examining your Health Insurance Card, which shows this information. If you only have one part of Medicare, you can get information about getting the other part from any social security office.

What Medicare Covers

MEDICARE HAS TWO PARTS:

- **Hospital Insurance (Part A)**

  Inpatient Hospital Care

  Post-Hospital Skilled Nursing Facility Care

  Post-Hospital Home Health Care

- **Medical Insurance (Part B)**

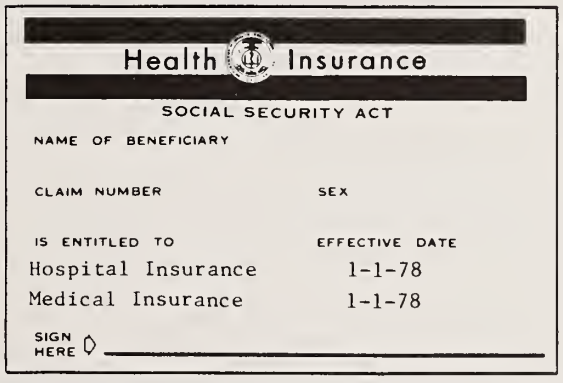
  Doctors' Services

  Outpatient Hospital Services

  Home Health Care
  (without a hospital stay)

  Other Health Care Services

This shows whether you have hospital insurance only, medical insurance only, or both


Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

CLAIM NUMBER SEX

IS ENTITLED TO EFFECTIVE DATE

Hospital Insurance 1-1-78

Medical Insurance 1-1-78

SIGN HERE

What Medicare Covers

HOSPITAL INSURANCE — BENEFIT PERIODS

The three benefits under Medicare's hospital insurance program—inpatient hospital care, skilled nursing facility care and home health care—are paid on the basis of *benefit* periods.

A benefit period *begins* when you enter a qualified hospital and *ends* when you have been out of a hospital or skilled nursing facility for 60 consecutive days. Then a new benefit period can begin the next time you enter a hospital. There is no limit to the number of benefit periods you can have, but after one benefit period begins, a new one cannot start until you have not been an inpatient in a hospital or skilled nursing facility for 60 days in a row.

Within *each* benefit period, Medicare hospital insurance will cover up to 90 days of inpatient hospital care, up to 100 days of inpatient skilled nursing facility care and up to 100 home health visits. Regardless of how many days or visits you use in one benefit period, the full amounts are restored each time a *new* benefit period begins.

What Medicare Covers

HOSPITAL INSURANCE

Benefit Periods

- *Begin* when you enter a qualified hospital.
- *End* when you're out of a hospital or skilled nursing facility for *60* days in a row.
- No limit to the *number* of benefit periods.

What Medicare Covers

HOSPITAL INSURANCE — WHEN YOU ARE A HOSPITAL INPATIENT

In *each* benefit period, you are entitled to as many as 90 days of inpatient hospital care in any hospital that participates in Medicare. Almost all hospitals in the U.S. do participate.

For the first 60 days of inpatient hospital care in a benefit period, you are responsible for the first $180 of expenses. This is called the *inpatient hospital deductible* and is charged only once in each benefit period. Except for this deductible, and the charges for noncovered services, such as telephone, television or a private room that is not medically necessary, Medicare hospital insurance pays for all the covered services you receive during your first 60 days of inpatient hospital care in each benefit period.

For the 61st through the 90th day of inpatient hospital care in each benefit period, Medicare hospital insurance will pay for all covered services except for $45 a day.

If you ever need to use more than 90 days in a benefit period, see pages 12 and 13 for a description of your "lifetime reserve" days.

The 90 days of inpatient hospital care in each benefit period do not have to be consecutive. For example, if you are in a hospital for 10 days and are then discharged, you would have 80 days that you can still use in that benefit period. If you stay out of a hospital or skilled nursing facility for 60 days in a row, of course, then a new benefit period starts the next time you enter a hospital and you full 90 days are reinstated. You must pay a new deductible for each new benefit period.

(The deductible and co-payment amounts shown in this book for inpatient hospital services and skilled nursing facility services are subject to change at the beginning of each calendar year. The amounts shown in this book are for calendar year 1980. You will find additional information about deductibles and co-payments under Medicare on page 28.

What Medicare Covers

HOSPITAL INSURANCE

When You're A Hospital Inpatient

- 90 Days per benefit period

  First 60 days—You pay *$180**, *Medicare pays the rest*

  61st thru 90th day—You pay *$45* a day, Medicare pays the rest*

- *Covered Services:* semi-private room, general nursing care, drugs, lab services, x-rays, operating and recovery room special care units, anesthesia, rehab services

*(1980 Amounts)

What Medicare Covers

HOSPITAL INSURANCE — LIFETIME RESERVE DAYS

The average inpatient hospital stay by Medicare beneficiaries is 11 days. For the great majority of beneficiaries, the 90 days of inpatient hospital care they are entitled to in *each* benefit period will cover all the inpatient hospital care they will ever need in their lifetime. Even if, on occasion, they have an above average hospital stay of, for example, 40 or 50 days, as soon as they are out of a hospital or skilled nursing facility for 60 days in a row, a *new* benefit period can begin and the original 90 days of inpatient hospital care can start over again. So, for most beneficiaries, Medicare hospital insurance is almost total protection against covered inpatient hospital care costs.

But, now and then, a beneficiary may need more than 90 days of inpatient hospital care in a benefit period. For that reason, Medicare hospital insurance provides 60 additional inpatient hospital days that can be drawn from whenever more than 90 days is required in a benefit period. These 60 days are called "lifetime reserve" days. This means that you can have as many as 150 covered days of inpatient hospital care in a benefit period. But once you use them, lifetime reserve days are *not replaced* when a new benefit period begins.

For each "lifetime reserve" day used, Medicare pays for all covered services except for $90 a day (for 1980).

What Medicare Covers

HOSPITAL INSURANCE

Lifetime Reserve Days

- 60 hospital days that can be used if more than 90 days of inpatient hospital care are needed in a benefit period.
- Cost you $90 each to use (1980 amount)
- Used "lifetime reserve" days *not* replaced when new benefit period begins.

What Medicare Covers

HOSPITAL INSURANCE — WHEN YOU ARE IN A SKILLED NURSING FACILITY

Sometimes, people who are receiving care as hospital inpatients reach the point in their treatment when they no longer need the intensive—and expensive—care furnished by the hospital, but are not well enough to go home. They still need skilled nursing care and rehabilitation services to help them in their recovery.

Medicare hospital insurance provides for as many as 100 days of posthospital care in a Medicare certified skilled nursing facility for beneficiaries who need this additional level of care. For the first 20 days of care in a skilled nursing facility in each benefit period, Medicare hospital insurance pays for all covered services. For the 21st through the 100th day, Medicare hospital insurance pays for all covered services *except* for *$22.50 a day* (for 1980).

Most "nursing homes," as that term is generally understood, are *not* skilled nursing facilities. Medicare only covers care in a skilled nursing facility and only when the care being furnished is medically necessary for the further treatment of a condition that was treated during the patient's hospital stay. Medicare does not cover care which mainly custodial—that is, care which is primarily needed to help in meeting personal care needs, such as eating, dressing, getting in and out of bed and taking medication.

What Medicare Covers

HOSPITAL INSURANCE

When You're In A Skilled Nursing Facility

- 100 days per benefit period

  First 20 days—Medicare pays all

  21st thru 100th day—You pay $22.50 per day, Medicare pays the rest (1980 amount)

- Covered services—semi-private room, general nursing care, drugs, rehab services, medical supplies and equipment

NOTE: Most nursing homes are NOT skilled nursing facilities.

What Medicare Covers

HOSPITAL INSURANCE — WHEN YOU RECEIVE HOME HEALTH SERVICES

Sometimes, after a hospital stay or after receiving care in a skilled nursing facility, people no longer need round-the-clock services in an institutional setting, but still need part-time convalescent care that can be provided in their own homes through periodic visits by skilled nurses, or physical or speech therapists.

To help meet this need, Medicare hospital insurance covers up to 100 home health visists for each benefit period, when skilled nursing and other therapy services are furnished by a home health agency participating in Medicare. Medicare pays the full reasonable costs for these visits. Under hospital insurance you have no deductible or co-payment for home health services. The services must be for further treatment of a condition for which you received care in your previous hospital or skilled nursing facility stay and *must* be furnished under a medical treatment plan supervised by your doctor. Medicare does *not* cover homemaker or other services which are *primarily* offered to assist you, such as help with dressing, bathing, eating, housekeeping and shopping.

What Medicare Covers

HOSPITAL INSURANCE

When You Receive Home Health Services

- 100 Visits Per Benefit Period—Medicare Pays All
- Covered Services. Part-time skilled nursing care, physical therapy, speech therapy.

  If you need any of the above services: Also covers part-time home health aide services, occupational therapy, medical social services, medical supplies and equipment

What Medicare Covers

MEDICAL INSURANCE — COVERED SERVICES

Medical insurance covers *doctor's services* regardless of where they are furnished—in the doctor's office, a clinic, a hospital or skilled nursing facility or in your home.

It covers *outpatient hospital services,* either in the hospital outpatient department or in the emergency room, both for diagnosis and for treatment services.

It covers services by *independent clinical laboratories* for diagnostic testing and covers 100 home health visits in each calendar year without the requirement of prior hospitalization. These home health visits can also be used *in addition to* the 100 visits available under hospital insurance.

Medical insurance also covers diagnostic X-ray and radiation therapy services, physical therapy services in a doctor's office, a clinic and, to a limited degree, in a physical therapist's office or in your home. It covers prosthetic devices, purchase or rental of durable medical equipment for use in your home, certain ambulance services and a number of other medical supplies and equipment.

The combination of medical insurance and hospital insurance provides a broad and comprehensive package of health insurance protection.

What Medicare Covers

MEDICAL INSURANCE

What Is Covered

- Doctors' Services
- Outpatient Hospital Services
- Laboratory Services
- X-Ray and Radiation Therapy Services
- 100 Home Health Visits a Year (without being in a hospital first)
- Physical Therapy and Speech Pathology Services
- Durable Medical Equipment
- Limited Ambulance Services
- Prosthetic Devices and Other Medical Supplies and Equipment

What Medicare Covers

MEDICAL INSURANCE — WHAT MEDICARE PAYS

Medical insurance pays 80 percent of the "reasonable charges" for covered services *after* an annual $60 deductible is met. The $60 annual deductible must represent covered services and is based on "reasonable charges" rather than actual bills.

"Reasonable charges" are updated every July 1 to try to keep pace with changes in medical care prices. Because this update is based on price information collected during the *preceding* year, and because price changes during the current period of high inflation have been more frequent than in the past, the "reasonable charges" on which medical insurance benefits are based are often less than the charges doctors and suppliers will bill you. As a result, 80 percent of "reasonable charges" will often be less than 80 percent of your bill from a doctor or supplier.

As we will note later, this difference between the actual charge to you and the "reasonable charge" on which Medicare benefits are based is one of the major gaps in Medicare. Very few private insurance policies exist which help you to meet this additional cost. Where your doctor or supplier takes an "assignment," discussed in the next section, you can avoid this additional expense.

What Medicare Covers

MEDICAL INSURANCE

What Medicare Pays

- 80 percent of "reasonable charges" after $60 annual deductible is met.

"*Reasonable charges*"—updated every July 1, based on actual charges by doctors and suppliers *in your area* during the *preceding* calendar year.

Reasonable Charges"—often *less* than what your doctor or supplier currently charges because of time "lag" and inflation.

What Medicare Covers

MEDICAL INSURANCE — ASSIGNMENT

The Medicare program has no legal authority to limit the amounts doctors and suppliers may charge Medicare beneficiaries. But the law authorizes a voluntary arrangement called "assignment." Under this arrangement, a doctor or supplier can agree to accept the Medicare payment directly from the program, but as a condition of such direct payment, must also agree to accept Medicare's "reasonable charge" as the total charge for the services covered by the assignment.

If your doctor or supplier accepts assignment, this means that he or she can only charge you for any of the $60 annual deductible not yet met, for 20 percent of the remaining "reasonable charges" and, of course, for any services not covered by the program. In an assignment case, you cannot be charged for any difference between the "reasonable charge" and the actual charge the doctor or supplier would otherwise have billed to you.

Assignment is a case-by-case choice. Some doctors and suppliers always take assignment. Some never accept assignment. Most will accept assignment on some claims, but not on others. It is a voluntary choice both for you and the doctor or supplier. Because it will usually be to your financial advantage, you should always ask.

What Medicare Covers

MEDICAL INSURANCE

When Your Doctor or Supplier Accepts Assignment

- Medicare payment is sent directly to doctor or supplier
- You are responsible for any of the $60 annual deductible not yet met
- 20 percent of the "reasonable charge"
- Any items or services *not* covered by Medicare
- Your Total Payment to the Doctor or Supplier Cannot Exceed the "Reasonable Charge" set by Medicare.

What Medicare Covers

MEDICAL INSURANCE — NONASSIGNMENT

When the doctor or supplier does *not* agree to an assignment, you must file the medical insurance claim and the Medicare payment is sent to you.

The medical insurance payment will be 80 percent of the "reasonable charge" for the covered services you received after your $60 annual deductible is met. You are responsible for the entire amount the doctor or supplier has billed you.

If the difference between the "reasonable charge" and the actual charge you are billed is large enough to cause a hardship, you should consider discussing the difference with the doctor or supplier. Some may be willing to adjust their charge in your favor or, at least, work out a payment arrangement over a longer period than usual.

What Medicare Covers

MEDICAL INSURANCE

When Your Doctor or Supplier Does *Not* Accept Assignment

- Medicare payment sent directly to you.
- You Are Responsible For The Entire Bill
- Your Medicare payment is 80 percent of the "reasonable charge" for covered services after the $60 annual deductible is met.

What Medicare Does Not Cover

THE THREE GAPS IN MEDICARE

There are three major categories of health care expenses not covered by Medicare that represent gaps. They are (1) the Medicare deductibles and co-payments for the services Medicare covers; (2) the medical items and services that Medicare does not cover at all, and (3) in non-assignment cases, the difference between the "reasonable charge" and the actual charge for covered services by doctors and suppliers under the medical insurance program.

We will discuss these three gaps in greater detail in the next few sections, because your choice of a private health insurance policy, if you decide you want and need added protection, should be based on a careful consideration of how well it fills the gaps in Medicare that you feel you should be insured against. The different types of private insurance you can buy offer different ways of filling these gaps to suit your different needs and preferences. As we will discuss later, the more you know about what Medicare covers and what it does not cover, and how these different kinds of private health insurance relate to the gaps in Medicare, the better choice you will make for your own individual situation.

Medicare Does Not Cover:

THE THREE GAPS

(1) Medicare deductibles and co-payments.

(2) Non-covered items and services.

(3) Charges exceeding "reasonable charges."

What Medicare Does Not Cover

DEDUCTIBLES AND CO-PAYMENTS

The deductibles and co-payments under Medicare are specific money amounts for covered services that the program does not pay, or in the case of blood, a specific initial quantity of blood for which you can be charged before Medicare assumes all or part of the additional costs.

In the hospital insurance program, there are basically 5 fixed amounts which the program does not pay even though the services are otherwise covered. These are: (1) the *$180* inpatient hospital deductible that you pay on your *first* admission to a hospital in each benefit period; (2) the *$45 a day* for the 61st through the 90th day of inpatient hospital care in each benefit period; (3) the *$90 a day* for each "lifetime reserve" day you use for inpatient hospital care after 90 days of such care in a benefit period; (4) the *$22.50 a day* for the 21st through the 100th day in each benefit period for care in a skilled nursing facility and, (5) the *first 3 pints of blood* you use in each benefit period in connection with covered hospital insurance services. The money amounts in the hospital insurance program are subject to change at the beginning of each calendar year, based on changes in hospital costs.

In the medical insurance program there are *3* such fixed amounts. These are (1) the *first $60 of covered medical expenses* in each calendar year—the annual medical insurance deductible; (2) *20 percent* of the "reasonable charges" for covered service and, (3) *the first 3 pints of blood* you use in a calendar year in connection with covered medical insurance services. This blood deductible is separate from the 3 pint blood deductible in the hospital insurance program—one cannot be used to meet the other.

The money amounts in the medical insurance program are established by law and can only be changed if the Medicare law is amended.

Medicare Does Not Cover:

DEDUCTIBLES AND CO-PAYMENTS

(1980 Amounts)

Hospital Insurance

- $180 for the first 60 days of inpatient hospital services in a benefit period (the inpatient hospital deductible).
- $45 a day for the 61st thru 90th day of inpatient hospital services in a benefit period.
- $90 a day for each "lifetime reserve" day used.
- $22.50 a day for the 21st thru 100th day in a benefit period for inpatient care in a skilled nursing facility.
- The first 3 pints of blood in a benefit period.

Medical Insurance

- The first $60 each year of "reasonable charges" for covered services (the annual medical insurance deductible).
- 20 percent of the "reasonable charges" for all covered services above the deductible.
- The first 3 pints of blood in a calendar year.

What Medicare Does Not Cover

NON-COVERED ITEMS AND SERVICES

The gap area represented by items and services *not covered at all* under Medicare is the area that involves the largest out-of-pocket costs by Medicare beneficiaries. It is also an area in which *very few* private health insurance policies offer significant additional protection.

The major services not covered by Medicare hospital insurance are: (1) services after 150 days of inpatient hospital care in a benefit period (after 90 days if you have used all your "lifetime reserve" days); (2) services after 100 days of inpatient skilled nursing facility care in a benefit period; (3) nursing home care in other than a skilled nursing facility; (4) more than 100 home health visits for a benefit period and, (5) a private room in a hospital or skilled nursing facility, or private duty nursing in either facility.

The major services not covered by Medicare medical insurance are: (1) more than 100 home health visits in a calendar year; (2) drugs and medicines you buy yourself; (3) eyeglasses (except prosthetic lenses after cataract surgery) and routine eye examination; (4) hearing aids and routine hearing loss examinations and, (5) dental care.

Neither hospital insurance nor medical insurance covers services which are not medically necessary, nor services in a foreign country (with some exceptions for Canada and Mexico).

Medicare Does Not Cover

NON-COVERED ITEMS AND SERVICES

Hospital Insurance

- More than 150 days of inpatient hospital care in a benefit period (over 90 days if you have used all your "lifetime reserve" days).
- More than 100 days of inpatient skilled nursing facility care in a benefit period.
- Nursing home care in other than a skilled nursing facility.
- More than 100 home-health visits for a benefit period.
- Private duty nursing.
- Private room (unless medically necessary).

Medical Insurance

- More than 100 home health visits in a calendar year.
- Drugs and medicines you buy yourself.
- Eyeglasses (except after cataract surgery)
- Hearing aids.
- Dental care.

- Care outside the United States.
- Services and supplies that are not medically necessary.

What Medicare Does Not Cover

CHARGES THAT EXCEED 'REASONABLE CHARGES'

As we discussed earlier, the "reasonable charge" on which Medicare bases its payments under the medical insurance program is often less than the amount billed to you by a doctor or supplier. In fact, in 1978 over 70 percent of all allowed claims under the medical insurance program were reduced because the billed amount exceeded the Medicare "reasonable charge."

Of the total money amount reduced approximately one-half was for unassigned claims. As you remember, when a claim is unassigned, the beneficiary, in addition to paying the deductible and co-payment, is responsible for paying the difference between the actual charge and the "reasonable charge." This large money amount for which beneficiaries are responsible in unassigned medical insurance claims is a major gap.

Very few private health insurance policies exist which cover these charges. Whenever possible, therefore, you should try to secure doctor and supplier services on an assignment basis.

Medicare Does Not Pay For:

CHARGES THAT EXCEED 'REASONABLE CHARGES'

- Over *70 percent* of all allowed Medicare claims in the medical insurance program in 1978 were *reduced* because the billed amount exceeded the "reasonable charge."
- The total amount reduced was almost *$2 billion*.
- Of this, almost half was for unassigned claims—a major out-of-pocket expense for the elderly.
- Few private insurance policies cover these charges.

Do You Need Private Health Insurance?

TWO IMPORTANT FACTS

Whether you need private health insurance in addition to your Medicare protection is a decision that only you can make. While Medicare covers a very substantial array of health care services, Medicare does not offer complete health insurance protection. Private health insurance, if it is carefully chosen, and if you can afford the additional expense, can help fill *some* of the gaps.

Most experts feel that if you can afford it, it is a good investment to buy the additional protection that private health insurance can provide, so long as you buy one of the better policies that offers you the kind of additional help you think you need most. But it is important for you not to be misled by the claims of a private insurer or a private insurance agent that you will be "fully" protected by buying private insurance.

One very important caution—if you are eligible for Medicaid, which is a health care program administered by the States which helps pay medical expenses for low income people, *do not* purchase private health insurance. The combination of Medicare and Medicaid pays almost all of your essential medical costs and those services that neither program covers are almost never covered by private health insurance policies.

Do You Need Private Health Insurance?

TWO IMPORTANT FACTS

- Private health insurance can help you fill *some*, but not all of the Medicare gaps.
- If you are eligible for *Medicaid, do not* purchase private health insurance. The combination of Medicare and Medicaid pays almost all essential medical costs.

What Kinds of Private Health Insurance Can You Buy?

BASIC TYPES

Private health insurers selling policies to add to your Medicare protection have designed a wide variety of policies to suit different needs and preferences. There are 7 basic types of such insurance.

They are: (1) continuation or conversion of a policy you have when you reach 65; (2) Medicare supplement policies, which are specifically designed to pay some of the money amounts that Medicare does not pay for covered services; (3) catastrophic or major medical expense policies, which are designed for high expense situations and do not begin paying until a large deductible is met; (4) Health Maintenance Organizations (HMOs), from which you purchase health care services directly for a fixed, periodic advance payment; (5) hospital indemnity policies, which pay cash amounts for each day of inpatient hospital services; (6) nursing home policies, which pay cash amounts for each day of covered nursing home care; and, (7) specified disease policies, which pay only when you need treatment for the disease insured against.

We will discuss each of these types of insurance in greater detail in the following sections.

What Kinds of Private Health Insurance Can You Buy?

BASIC TYPES OF PRIVATE HEALTH INSURANCE

- Continuation or conversion of pre-65 coverage
- Medicare supplement policies
- Catastrophic or major medical expense
- Health maintenance organizations (HMOs)
- Limited Coverage Policies:
  —Hospital indemnity
  —Nursing home coverage
  —Specified disease coverage

What Kinds of Private Health Insurance Can You Buy?

CONTINUATION OR CONVERSION OF PRE-65 COVERAGE

Many people, upon reaching age 65, already have private insurance coverage, either privately purchased or, more frequently, in connection with their current employment. In these situations, most insurers will either permit continuation of coverage or conversion to a modified coverage taking your new Medicare coverage into account. If your prior insurance was partly funded by your employer, that premium sharing can sometimes continue in connection with your after-65 coverage.

While your decision to continue or convert existing coverage should be primarily based on how well such insurance will meet your individual needs, most experts rate this option as one of the best buys in additional health insurance protection for a number of reasons. First, you have uninterrupted coverage. Second, continued or converted coverage usually requires no medical history since that has already been established, so that there are no pre-existing condition exclusions. Third, if the prior policy was based on your employment, the continued or converted coverage is usually based on group premium rates, which are often lower than the premium rates for individually purchased policies. And, of course, if your employer continues to share in the premium costs, your premium costs will be significantly reduced. You should ask your employer for a written outline of your post-retirement health insurance benefits.

One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you are aware of what effect the continued or converted coverage will have on his or her insurance protection.

17

What Kinds of Private Health Insurance Can You Buy?

CONTINUATION OR CONVERSION OF PRE-65 COVERAGE

- No waiting periods
- No pre-existing condition exclusions
- No medical data required
- Often includes spouse
- Employer often pays part of premium

What Kinds of Private Health Insurance Can you Buy?

MEDICARE SUPPLEMENT POLICIES

Medicare supplement policies primarily cover some or all of the deductible and co-payment money amounts Medicare does not pay. Sometimes they offer extensions of coverage for the services Medicare covers only up to certain maximums, such as the number of covered hospital days in a benefit period. The essential characteristic of a "Medicare Supplement" policy is that it usually only covers the *same services that Medicare covers,* but fills in some or all of the Medicare nonpayment gaps for those services.

Some Medicare supplement policies add additional coverages for services Medicare does not cover at all, such as drugs and medicines, but this is the exception rather than the rule. Very few Medicare supplement policies cover the difference between actual charges and "reasonable" charges for unassigned Medicare medical insurance claims for services by doctors and suppliers.

Most experts, however, feel that Medicare supplement policies offer excellent additional protection to Medicare beneficiaries if they cover deductibles and co-payments under *both* the Medicare hospital and medical insurance and offer extensions of inpatient hospital day limits under Medicare, and particularly if they cover drugs and medicines to some degree.

What Kinds of Private Health Insurance Can You Buy?

MEDICARE SUPPLEMENT POLICIES

- Mainly cover only services *also* covered by Medicare; pay some or all deductibles and co-payments Medicare does not pay.
- The best Medicare supplement policies cover—
  Deductibles and co-payments under *both* hospital insurance and medical insurance.

  Additional days of inpatient hospital and skilled nursing facility care or additional home health visits.

What Kinds of Private Health Insurance Can You Buy?

CATASTROPHIC OR MAJOR MEDICAL EXPENSE

Some people may feel that they can afford Medicare deductibles and co-payments or, because they have limited funds to spend on insurance premiums, may feel that they would rather insure against major expenses than against the smaller, periodic Medicare deductible and co-payment costs.

Catastrophic or major medical expense policies are designed for such preferences. Generally, a catastrophic or major medical expense policy will have a high initial deductible such as $500 or $1,000, before it begins paying. Thereafter, however, it will pay up to very large amounts, such as $250,000, for the service it covers.

Very few catastrophic or major medical policies are available to people over 65 on an individual purchase basis. Most such policies are continuations of pre-65 coverage or are available only on the basis of membership in a group or association. Where such policies are available and, of course, depending on the quality of the specific policy, catastrophic or major medical expense policies may be a good buy for those who feel that their greatest insurance priority is to protect themselves and their families from the high costs of an extended illness requiring expensive medical care.

What Kinds of Private Health Insurance Can You Buy?

CATASTROPHIC OR MAJOR MEDICAL EXPENSE

- Usually covers health care expenses after a large deductible is met (generally $500–$1,000).
- Excellent coverage for people who can afford Medicare deductibles and co-payments out-of-pocket, or who have a good basic insurance coverage.
- Not widely available after 65—usually continuation of pre-65 coverage.

What Kinds of Private Health Insurance Can You Buy?

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

If there is a Health Maintenance Organization (HMO) in your area that is participating in Medicare, you may wish to consider this option. For people with Medicare, membership in an HMO offers additional protection similar to the purchase of a Medicare supplement policy.

An HMO is an organization that offers direct health services from its own doctors, hospitals, and other health delivery resources in return for a membership fee paid in advance, usually on a monthly basis. In effect, it both insures and provides health care services. It is, in short, a pre-paid health care system.

When you join a Medicare-participating HMO, you pay a membership premium to cover the Medicare deductible and co-payment costs, so that all Medicare-covered services are available to you without any additional cost. This means that, since all your Medicare covered services are prepaid under your HMO membership premium, you do not have to file any claims.

Many HMOs offer health care services in addition to those covered by Medicare, such as additional days of care or coverage of drugs and medicines. Some HMOs provide the additional services without increased premiums; others may charge a small added fee.

What Kinds of Private Health Insurance Can You Buy?

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

(HMOs)

- Combined health insurance *and* health care delivery arrangement.
- In an HMO participating in Medicare—
  - —You pay a membership fee.
  - —All services covered by Medicare are furnished *through* the HMO.
  - —Membership fee covers Medicare deductibles and coinsurance.
  - —Services are pre-paid; no claims process.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE -
HOSPITAL INDEMNITY

Hospital indemnity policies are a limited coverage type of policy in that they offer protection only for inpatient hospital care.

These policies usually pay a fixed amount on a per-day basis, for example, $30 a day for *each* day of inpatient hospital occupancy. Coverage may begin on the first day of hospitalization or on a later date. Some policies have a maximum number of days or a maximum payment amount. Some do not become effective immediately, but require a 3-month or more waiting period. Many exclude coverage for pre-existing conditions for one or two years or exclude certain pre-existing conditions permanently.

Generally, a hospital indemnity policy will pay the specified daily amount regardless of any other health insurance coverage you have. Many experts feel that, *if* you are insured with a good general coverage, *basic* policy in addition to Medicare, a hospital indemnity policy can sometimes be valuable additional protection for those who can afford it. This is because it pays cash during a hospital stay that can help in meeting the additional personal and family expenses associated with a hospital stay. Other experts, however, note that the average hospital stay for Medicare beneficiaries is approximately 11 days. Further, they observe that the average beneficiary after reaching age 65 has three or four hospital admissions in his or her lifetime. They conclude, therefore, that hospital indemnity policies are not as good an insurance investment as more comprehensive supplementary policies would be.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Hospital Indemnity Policies

- Per day cash payments.
- Only pay for actual days in hospital.
- Often do not begin on first day of hospitalization.
- Often have maximum number of days or maximum payment amount for single hospitalization.
- Do not increase per day payments with inflation.
- May have pre-existing condition exclusions.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE -
NURSING HOME COVERAGE

Some private health insurers sell what are advertised as "nursing home" policies. These policies generally pay a per-day amount for each day of care in a "nursing home." Before buying this kind of limited coverage policy it is extremely important that you fully understand *exactly* what is covered and what is *not* covered.

Nursing homes are classified into three broad types: (1) *skilled nursing facilities,* primarily furnishing medical treatment and rehabilitative services; (2) *intermediate care facilities,* primarily furnishing personal care and medical management services, but also having skilled nursing personnel and rehabilitative services available on an as-needed basis; and (3) *residential or personal care facilities,* primarily furnishing personal support services, such as help in eating, dressing, bathing, and taking medications.

Most "nursing home" policies on the market *only* cover medically necessary care in a *skilled* nursing facility. The great majority of elderly people who need nursing home care are in intermediate or personal care facilities, because their primary need is for assistance and support services resulting from their increasing inability to care for themselves in their own homes, even with the help of other family members. Many people buying "nursing home" policies, believing that they protecting themselves against the day when they can no longer care for themselves at home, have been disappointed to discover that their policy does not cover such "nursing home" care.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Nursing Home Coverage Policies

- Usually pay per-day amounts.
- Rarely cover care in other than skilled nursing facilities.
- Rarely cover care that is primarily *custodial*—care mainly to meet personal care needs such as bathing, feeding, dressing, taking medicine.
- Most U.S. nursing homes are not skilled nursing facilities.
- Most nursing home care needed by the elderly is custodial—i.e., personal care.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE - SPECIFIED DISEASE POLICIES

A few insurers offer policies which are limited to treatment for a specific illness or a group of specific diseases. The most common type of policy in this area is cancer insurance.

Most experts caution purchasers to examine this kind of insurance very carefully.

First of all, Medicare covers much of the care needed by people with cancer and other diseases covered by a specified disease policy. Sometimes a specified disease policy has what is called a "coordination of benefits" clause. It does not pay, or pays far less than expected, when another insurer, such as Medicare, is covering the same costs.

Secondly, many of these policies have very restrictive conditions regarding the type of treatment covered and in what types of facilities covered treatment can be reimbursed.

Thirdly, many of these policies have low maximum payments amounts which are quickly exhausted in the event of a long treatment period.

What Kinds of Private Health Insurance Can You Buy?

LIMITED COVERAGE

Specified Disease Policies

- Usually cover single type of disease such as cancer or heart disease.
- Usually have maximum payment amounts for specific types of treatment.
- Often have restrictive conditions.

Hints For Buying Private Health Insurance

SHOPPING HINT #1

Do Not Buy More Policies Than You Need

- Many policies have a "coordination of benefits" clause—policy will not pay when another insurer pays or each insurer will pay part of the costs, not to exceed total actual cost.
- Duplicate coverage often means multiple premiums with no greater protection than a single good policy.

Hints For Buying Private Health Insurance

SHOPPING HINT #2

Check For Pre-Existing Condition Exclusions and Waiting Periods

Be sure you know:

- When new policy begins paying.
- If any medical conditions are permanently excluded or not payable until a future date.
- You have this information in writing.

Hints For Buying Private Health Insurance

SHOPPING HINT #3

Be Careful About Replacing Existing Coverage

- Usually a waiting period.
- Your current medical condition may affect your new coverage.

—*However*, do not keep an inadequate policy just because you have had it a long time.
—If you do replace it, keep old policy until new one becomes effective.

Hints For Buying Private Health Insurance

SHOPPING HINT #4

Be Aware of Maximum Benefits

- Many policies have maximum payment amount under entire policy or for specific treatments. Some have maximum number of days or visits.
- Get the maximums in writing to see if they meet your needs.

Hints For Buying Private Health Insurance

SHOPPING HINT #5

Check Your Right To Renew

- Avoid policies "renewable at company option." Company could cancel your *individual* policy for any reason at end of policy year or when premium comes due.

Hints For Buying Private Health Insurance

SHOPPING HINT #6

Beware of the "Government Look"

- Implied government affiliation or endorsement.
- Advertising literature designed to look "Governmental"—
  —Social Security envelope size.
  —Official-looking seal.
  —Correspondence begins with "Dear Medicare Member."

REMEMBER

—*No* private insurance company selling insurance to add to Medicare is affiliated with or endorsed by the Federal Government.

Hints For Buying Private Health Insurance

SHOPPING HINT #7

Take Your Time

- Don't be "high pressured."
- Beware of "short-term" enrollment periods or "last chance to enroll" statements. Ethical salespeople never "high-pressure" you.
- Buying insurance is an important decision. Take enough time to feel confident about your choice. Consult others if you can.

Hints For Buying Private Health Insurance

SHOPPING HINT #8

Beware of "Scare Tactics"

- Agent or advertising literature describes extreme situations to frighten purchaser.
  —Exaggerated expenses.
  —Exaggerated likelihood of illness.

REMEMBER

- Less than 1 percent of the elderly exhaust their Medicare hospital benefits.
- Only 4 percent of the elderly are in nursing homes.
- Few private health insurance policies cover services Medicare does not cover.

Hints For Buying Private Health Insurance

SHOPPING HINT #9

Do Not Withhold Medical Information

- Withholding medical information on a policy application may lead to non-payment for a later claim.
- Never believe salespersons who say you don't have to furnish such information when the application requests it or say they will fill in that information later.

Hints For Buying Private Health Insurance

SHOPPING HINT #10

Get a Written Outline of Coverage

- Always ask for a written description of the policy you are considering buying—in simple language.
- A company selling a good policy will always provide a simplified description of what they are offering for sale.
- Read it carefully.

Hints For Buying Private Health Insurance

SHOPPING HINT #11

Do Not Pay Cash

- Always pay by check, money order, or bank draft made out to the insurance company—never to the agent or anyone else.
- Always write down the name and address of the agent or insurance company, so you can follow up if there is any delay in getting your policy.

Hints For Buying Private Health Insurance

SHOPPING HINT #12

Make Sure There Is A "Free Look" Provision

- Most reputable insurance companies have at least a 10-day period after you receive your policy to look it over. During that period, if you decide you don't want it, you can return it for a full refund of your premium.
- Beware of any insurance policy that is on a "take it or leave it" basis and does not give you a grace period to change your mind.

For Further Information

Using the Medicare/Private Insurance Checklist

The Medicare/Private Health Insurance Checklist for the major types of supplemental insurance is designed to help you quickly determine how well a particular policy will meet your health insurance needs.

In Part I, **Medicare Supplement Policies,** by checking the "yes" and "no" blocks and filling in the block showing how much the policy pays, you will be able to see exactly how well the listed "gaps" in Medicare coverage are met by the policy you are considering.
In Part II, **Hospital Indemnity Policies,** the answers to the questions will help you to determine whether the particular policy offers as much protection as you are seeking in this limited area of coverage.
The questions in Part III, **Nursing Home Policies,** will help you determine exactly what kinds of nursing homes are covered by the policy and under what conditions the policy will pay.

I MEDICARE SUPPLEMENT POLICIES
Use this section for insurance policies that promise to pay "all the expenses that Medicare does not pay" or which promise to pay "all the gaps in Medicare." By checking the "yes" and "no" blocks for each of the listed items that Medicare does not cover and, answering the other questions, you will be able to see at a glance just how well the proposed policy can help you meet the health care expenses Medicare does not pay.

II HOSPITAL INDEMNITY POLICIES
Use this section for insurance policies that promise to pay "cash" for each day you are a hospital inpatient. Remember that hospital indemnity policies always pay on a per-day basis. Do not be misled by policies which advertise, for example, "$1500 per month." That is only about $50 a day and the policy will not pay for any days you are not in the hospital. In addition, be sure you know on what day of your stay the daily payments begin and whether there is a maximum number of days or total amount that can be paid.

III NURSING HOME POLICIES
Use this section for insurance policies that promise to pay for "nursing home" care. Nursing home policies are usually very limited and exclude care that most people associate with the phrase "nursing home." Be sure you know *what kind* of nursing home care is covered. Most nursing home policies cover *only* medically necessary care in a *skilled nursing facility,* and do not cover custodial or long-term care in either a skilled nursing facility or other type of nursing home.

NOTE: Examine specific disease policies, such as Cancer Insurance, very carefully. We suggest you seek professional advice.

I. Medicare Supplement Policies

NOT COVERED BY MEDICARE (1980 figures Subject to Change in 1981)	COVERED BY PROPOSED POLICY? YES	NO	WHAT DOES PROPOSED POLICY PAY?
$180 for the first 60 days of inpatient hospital services in a benefit period (the inpatient hospital deductible)			
$45 a day for the 61st to 90th day of inpatient hospital services in a benefit period			
$90 a day for inpatient hospital services for each "lifetime reserve" day used (can be used up to a total of 60 days in your lifetime, whenever you need more than 90 days in a benefit period)			
Over 150 days of inpatient hospital services in a benefit period (over 90 days if you have used all your "lifetime reserve" days)			
$22.50 a day for the 21st to 100th day in a benefit period for inpatient services in a skilled nursing facility			
Over 100 days of inpatient skilled nursing facility care in a benefit period.			
Nursing home care in *other* than a skilled nursing facility.			
Private room in a hospital or skilled nursing facility (except when medically necessary)			
Private duty nurses in a hospital or skilled nursing facility.			
Over 100 home health visits for each benefit period under Medicare hospital insurance			
Over 100 home health visits in each calendar year under Medicare medical insurance			
The first 3 pints of blood under either Medicare hospital *or* medical insurance			
The first $60 of doctor bills and other medical services and supplies under Medicare medical insurance (the medical insurance annual deductible)			

Medicare Supplement Policies (cont.)

NOT COVERED BY MEDICARE (1980 figures — Subject to Change in 1981)	COVERED BY PROPOSED POLICY? YES	NO	WHAT DOES PROPOSED POLICY PAY?
After the first $60, 20% of "reasonable charges" for doctor bills and other bills for covered medical services and supplies under Medicare medical insurance.			
Charges *above* the Medicare "reasonable charge" in non-assignment cases.			
Drugs and medicines you buy yourself			
Eyeglasses (except after cataract surgery)			
Hearing aids			
Dental care			
Medical care outside the United States			

Are there any additional benefits the proposed policy pays? YES ☐ NO ☐

If yes, describe. _____

_____

_____

_____

a. Is there a pre-existing condition exclusion? YES ☐ NO ☐

If yes, what conditions are excluded and for how long? _____

_____

_____

_____

b. Is there a waiting period before policy pays benefits ? YES ☐ NO ☐

If yes, when does the policy begin paying benefits? _____

II. Hospital Indemnity Policies

a. What is the daily payment rate? $ _____ per day

b. On what day of a hospital stay do payments begin? _____

c. What is the maximum number of days the policy will pay? _____

d. Is there a maximum payment provision? If yes, what is the maximum amount? _____ YES ☐ NO ☐

e. Are there any excluded illnesses? If yes, describe. YES ☐ NO ☐

_____

_____

f. Are there any benefits in addition to the daily payment rate? If yes, describe. YES ☐ NO ☐

_____

_____

III. Nursing Home Policies

a. Does the policy cover care in facilities other than skilled nursing facilities? YES ☐ NO ☐

If yes, what other kinds of nursing homes?

_____

_____

b. Does the policy cover your stay in a skilled nursing facility or other nursing home when the care you need is primarily *custodial* care, that is, mainly personal care, such as help in feeding, dressing, getting in and out of bed, and taking medicine. YES ☐ NO ☐

If yes, under what conditions and for how long will the policy pay for such care?

_____

_____

c. Are there any excluded illnesses. If yes, describe. YES ☐ NO ☐

_____

_____

_____

CMS LIBRARY
3 8095 00014275 8

U.S. Department of Health and Human Services
Health Care Financing Administration

(HCFA) 80-01 001